

OFFICE POLICIES

Welcome to Louisville Dental Associates. We sincerely appreciate your trust in choosing us as your dental provider. We strive to provide the best quality service possible and would like to inform you of our office policies and your responsibilities.

As a courtesy to our patients we bill ALL insurance claims. Payment will be accepted from the insurance company, but we ask that you pay your portion including deductibles -at the time of service. Any claims that have been disputed or not paid within a reasonable time (usually 90 days) by the insurance company will become your responsibility. Ultimately the financial obligations incurred by treatment are yours, regardless of insurance benefits. Insurance reimbursement is a contract between you and your insurance provider.

It is our patient's responsibility to know their insurance benefits! While we make every effort to be familiar with most plans we cannot guarantee we will know specifics about your plan. It has become impossible for this office to know everyone's plan limitations. We therefore encourage our patients to become familiar with their plan coverages and know their limitations, such as age limits, frequency limits, waiting periods, and other restrictions. We will be happy to review a copy of your policy with you to ensure that you understand.

We accept cash, checks, Visa, MasterCard, Discover, and American Express.

It is important that we have consent to treat minors and have a current medical history update. If children are sent to appointments without an accompanying parent or adult, then prior permission must be given for treatment, such as x-rays and fluoride treatments. Arrangements for payment should also be made in advance for services provided to minors. Payment for that date of service can be sent with the child or authorized for credit card payment. We can keep your credit card number on file for these purposes.

We strive to call patients 24-48 hours in advance to confirm appointments. We request that if you have to change your appointment you do so with 24 hours notice as a courtesy to this office and other patients who are waiting to be seen. In the unfortunate event that a patient cancels or changes an appointment 3 times without 24 hours notice (unless it is a valid emergency) or no-shows 3 times, the patient will be asked to choose another dentist.

Once a patient has had to be sent to a collection agency, they will be asked to choose another dentist.

Again, it is our pleasure to serve you and we look forward to a very long, enjoyable relationship.

Signature: _____ Date: _____